Yin and Tonic Acupuncture P.C.
265 W 37th St Suite 640 @ 8th Ave
New York, NY 10018

Please note that all information is strictly confidential.

First Name: Middle Initial:

Last Name:

Address: City/State/Zip:

E-mail Address: Cell Phone:

Home Phone: Work Phone:

Occupation:

In Case of Emergency Contact:

Relationship & Phone:

Height_____ Weight_____ Age_____

OBGYN Name_____ Phone _____

Reproductive Endocrinologist:

Name_____Phone_____

Other relevant physicians/specialists_____

_____

May I discuss your treatment with your RE/OBGYN? Yes No

How did you hear about Yin and Tonic?_____

Reason for Today's Visit: _____

_____

_____

How, when and where did this condition begin _____

_____

What types of treatments have you tried (if you are a fertility patient please be as detailed as possible): _____

_____

_____

_____

_____

Please list your main health problems you would like to address in order of importance:

1. _____
2. _____
3. _____

Your Medical History:

Surgeries, Major Illnesses, Hospitalizations, and Major Accidents:

_____

_____

_____

Current medications, supplements and vitamins (and what they are for)

_____

_____

_____

Do you have, or have you had any of the following illnesses?

□ Mental Illness □ Diabetes □ Hepatitis □ HIV+ □ Seizures □ Cancer
□ Heart Disease □ Asthma □ Allergies □ Stroke □ Arthritis □ Ulcers

□ High Blood Pressure □ Herpes □ Tuberculosis □ Osteoporosis
□ Rheumatic Fever □ Thyroid Problems □ AIDS □ Mononucleosis
□ Gall Stones □ Kidney Stones □ Other STDs
□ Chronic Fatigue □ Other _____

Lifestyle:

Describe what you eat: _____

_____

_____

Exercise? Yes No How often? _____

Type? _____

Sleep: Hours per night_____ Time to bed_____ Time to rise_____

Rested in AM? _____ Trouble falling asleep? Yes No Sometimes

Waking up at night? Yes No Get up to urinate more than once? Yes No

Work: Enjoy work? Yes No Hours per week working_____

Body Systems Review (please check all that apply):

0 = never 1 = in the past but not now 2 = occasionally 3 = frequently
4 = almost always

0	1	2	3	4	low appetite	0	1	2	3	4	heavy limbs
0	1	2	3	4	loose stools	0	1	2	3	4	fatigue
0	1	2	3	4	abdominal gas/bloating after food	0	1	2	3	4	hemorrhoids
0	1	2	3	4	fatigue after eating	0	1	2	3	4	belching
0	1	2	3	4	organ prolapse	0	1	2	3	4	nausea
0	1	2	3	4	bruise easily	0	1	2	3	4	diarrhea
0	1	2	3	4	obsessive thoughts/worrying	0	1	2	3	4	craving for sweets
0	1	2	3	4	spontaneous sweat	0	1	2	3	4	feeling of sadness
0	1	2	3	4	allergies	0	1	2	3	4	catch colds easily
0	1	2	3	4	asthma	0	1	2	3	4	feel tired after exercise
0	1	2	3	4	shortness of breath	0	1	2	3	4	general weakness
0	1	2	3	4	cough	0	1	2	3	4	nasal discharge
0	1	2	3	4	dry nose/mouth/skin/throat	0	1	2	3	4	sinus congestion
0	1	2	3	4	sore, cold or weak knees	0	1	2	3	4	feeling cold
0	1	2	3	4	low back pain	0	1	2	3	4	edema
0	1	2	3	4	frequent urination	0	1	2	3	4	hair loss
0	1	2	3	4	urinary incontinence	0	1	2	3	4	memory loss
0	1	2	3	4	ear problems	0	1	2	3	4	hotflashes
0	1	2	3	4	early morning diarrhea	0	1	2	3	4	nightsweats
0	1	2	3	4	craving salt	high low normal libido					

0	1	2	3	4	irritable	0	1	2	3	4	muscle spasms/twitches
0	1	2	3	4	feel better after exercise	0	1	2	3	4	heartburn/acid reflux
0	1	2	3	4	tight feeling in chest	0	1	2	3	4	dry eyes/red eyes
0	1	2	3	4	alternating diarrhea/constipation	0	1	2	3	4	ear ringing
0	1	2	3	4	symptoms worse with stress	0	1	2	3	4	anger easily
0	1	2	3	4	neck/shoulder tension	0	1	2	3	4	sand in eyes
0	1	2	3	4	floaters in vision	0	1	2	3	4	hair loss
0	1	2	3	4	brittle or weak nails	0	1	2	3	4	frequent headaches
0	1	2	3	4	feeling of heat rushing to head	0	1	2	3	4	blurry vision

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0	1	2	3	4	feel heart beating	0	1	2	3	4	chest pain
0	1	2	3	4	insomnia	0	1	2	3	4	disturbing dreams
0	1	2	3	4	sores on tip of tongue	0	1	2	3	4	excessive laughter
0	1	2	3	4	anxiety	0	1	2	3	4	palpitations
0	1	2	3	4	restlessness	0	1	2	3	4	excessive sweat
0	1	2	3	4	red cheeks						

Urination: Burning Urgent Retention Frequent
Scanty Profuse Dribbling
Cloudy Dark Pale

Wake to urinate more than 1X a night? Yes No

Bowel Movements: Frequency _____ When? _____

Feels complete? Yes No

Consistency- Well-formed Hard Loose Alternates

In stools? Undigested food Blood Mucus

Are you thirsty? Yes No If so do you crave warm or cold drinks? _____

Do find that you "run" particularly hot or cold?_____

How is your energy in general? _____

Do you often get headaches or migraines? Yes No

If yes where do feel the pain?_____

_____

Are they dull and aching or sharp and stabbing in nature?_____

_____

When do you normally get them?_____

_____

How do you feel emotionally right now? _____

_____

Women Only:

No. of pregnancies: _____ No. of children: _____ Age of first period: _____

Infertility: Yes No Maybe On the Pill? Yes No Abortions? Yes No

Have you experienced menopause? Yes No When?_____

(If yes, please skip the next section)

If you are experiencing menopausal symptoms, please describe _____

_____

_____

Date of last menstrual cycle? _____ Are you pregnant now? _____

Is your period regular? Yes No

No. of days from the start of one period to the start of the next:_____

Average number of days of flow: _____

Flow is: Light Normal Heavy

Color is: Pale Red Dark Red Red Brown Purple

Blood clots? Yes No How big/color?_____

Do you get pain or cramps? Yes No Severe? Yes No

Do you experience any of the following before or during your period each month?

□ Water retention □ Breast tenderness or swelling □ Emotional upset
□ Irritability □ Food cravings □ Migraines □ Other_____

Do you ever bleed between periods? Yes No

Do you have any unusual vaginal discharge? Yes No

Have you ever had any of the following:

□ Abdominal surgery □ LEEP procedure □ Fibroids □ Polyps □ IUD
□ Endometriosis □ Chlamydia □ Ectopic Pregnancy

Do you know your FSH level?_____

Have you recently had your estrogen/progesterone levels taken? If so what are they?

_____

_____

Please describe any reproductive procedures you have been through or are going through currently that you have not listed above. Please include procedures that involve both sexes:_____

_____

_____

_____

Men Only:

Prostate problems: Yes No Premature ejaculation: Yes No

Impotence: Yes No Infertility: Yes No

Morphology/Sperm count problems: Yes No

I am committed to your health and well-being. While Chinese Medicine is a very thorough health care system it is not a replacement for western treatment including regular check ups with your primary care physician and OBGYN. I recommend that you consult a physician regarding any condition or conditions for which you are seeking acupuncture treatment.

We, the undersigned, do affirm that _____ (print patient name) has been advised by Victoria Koos L.Ac. to consult a physician regarding the condition or conditions for which such patient seeks acupuncture treatment.

Patient Signature: _____**Date**:_____

Print Practitioner Name_____

Practitioner Signature_____**Date**_____

I consent to acupuncture treatments and other procedures associated with Traditional Oriental Medicine by Victoria Koos LAc. I have discussed the nature of my treatment with Victoria Koos LAc.

I understand that methods of treatment may include but are not limited to: Acupuncture, moxibustion, cupping, guasha, electrical stimulation, tui na (Chinese massage), Chinese herbal medicine.

I have been informed that acupuncture is a safe method of treatment, but that it may have side effects including bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. Bruising is a common side effect of cupping and guasha. Unusual risks of acupuncture include pneumothorax and organ puncture. Slight superficial burns are a possible side effect of moxibustion.

I acknowledge that if I don't give 24 hours notice for cancellation of an appointment, I will be charged a full fee for the missed appointment.

Patient Signature: _____ **Date:** _____